

lymphoma that had also involved hilar nodes and liver. There was no hepatic cirrhosis. Intraoperative portal pressure decreased from 16 cm to 5 cm of water after splenectomy. No bleeding episodes had occurred in the 12 months since splenectomy when the patient was last seen.

Isolated gastric varices are thought to result from elevated fluid pressure transmitted from the splenic vein through the connecting short gastric veins. Regardless of the fundamental cause of this increased pressure, splenectomy apparently relieves the varices and stops further bleeding. Diagnosis of bleeding gastric varices by endoscopy may be difficult, arteriography is often diagnostic but may allow false diagnosis of a tumor, and subsequent biopsy can lead to catastrophe.⁴

Massive splenomegaly is seen in a variety of diseases, including lymphomas and other infiltrative processes. As much as 55% of total blood flow can pass through such a spleen, constituting an arteriovenous shunt⁵; in our case, the high flow produced secondary gastric varices that bled profusely. Although the medical literature appears not to include reports of this condition, isolated gastric variceal bleeding should be considered in any patient with primary splenomegaly, and splenectomy may provide the cure.

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Overtreatment and Mistreatment of Wounds and Burns

TO THE EDITOR: Two surgeons were changing dressings on patients they had operated on two days before. In both cases the wounds had been uncontaminated and no drains had been used. The first surgeon donned cap, mask and gloves and used instruments to remove the old dressings and to wash around the wound with an antiseptic. Then he applied an expensive inner dressing of fine mesh gauze impregnated with an air-occlusive antibacterial ointment. On top of that he put additional dressings and lots of tape.

The second surgeon simply took off the old dressing on his patient, examined the wound and, finding it satisfactory, just left it open to the air.

The floor nurses and the infection control nurse think the first surgeon is wonderful and the second surgeon is sloppy. But which surgeon has the most wound infections? There really is not much difference but I have tried both methods and got fewer stitch infections with the open, dry technique. Germs don't grow in dry places.

Since many surgeons today do leave wounds open, particularly after the initial dressing, and since they have such good

results, why should others go through all that rigamarole? And it may easily cost the patient \$12 each time.

Well, these were clean and closed wounds, but what about open wounds such as deep abrasions, burns and small lacerations that have not been sutured? The conventional wisdom is to smear them up with an antibacterial cream or ointment and to occlude the oozing raw surfaces further with "ouchless" dressings that "won't stick."

We should ask ourselves why we use dressing at all. Animals recover from prodigious wounds without dressings and without clinical infections. They lick their open wounds to remove dirt and coagulum and to allow air into the deeper parts. Their saliva is far from sterile but cleansing, debridement and drainage is accomplished with usual success.

Cleansing, debridement and drainage—we can best accomplish these by soaking open wounds, including burns, two or three times a day, usually at home in the bathtub or shower or with a wet towel and by gently wiping with cotton or even a washcloth. No, we do not have to actually lick our wounds, but we do much the same in this way.

Our problem stems from the common belief that we must keep every germ *out* of such open wounds. The fact is that we cannot; skin cannot be sterilized anyway. Instead, we should concern ourselves with getting rid of the germs that are in there already. Tap water is not sterile but contains less than 1 millionth of the number of germs that can be found in pus. We should not be afraid to use it.

We should use simple gauze dressings sparingly and only to stop bleeding at the very first or to keep clothing from getting soiled where clothing must be worn. Such a dressing will come off easily when the patient is soaking it those two or three times a day.

With these principles, a number of us have found much quicker healing with less pain or discomfort, fewer hospital admissions and, of course, great savings.

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Osteoporosis and the American Diet

TO THE EDITOR: I read with interest the article on prevention of osteoporosis and osteoporotic fractures in the November 1985 issue.¹ There is considerable evidence to indicate that the typical American diet which is very high in protein may be a major factor in osteoporosis in this country. The breakdown products of a high protein diet are eliminated by the kidneys, causing excess loss of calcium. This risk factor is mentioned very briefly in the article. We have been led to believe in this country that high protein intake through meat and dairy products is essential to our well-being. Perhaps an emphasis on lower protein intakes would cut down on the risks of osteoporosis as well as of calcium-based urinary calculi.

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